	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				A. BUILDING:			
		FCL045102		B. WING		12/	31/2014
NAME OF PI	ROVIDER OR SUPPLIER	ST	REET ADD	RESS, CITY, STA	TE, ZIP CODE		
SOUNDVI	EW FAMILY CARE HOME	E UNIT N		IONET COURT K, NC 28731	ī		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 000	C 000 Initial Comments			C 000			
	The Adult Care Licensure Section and the Henderson County Department of Social Services conducted an annual survey on December 30-31, 2014.						
C 330	10A NCAC 13G .1004 Administration	4(a) Medication		C 330			
	10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.						
	This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, interview, and record review the facility failed to assure Humalog and Levemir insulins and Lisinopril were administered as prescribed for 2 of 3 sampled residents (Resident #1 and Resident #3).						
	The findings are:						
	11/20/14 revealed: -Diagnoses included open reduction and ir type 2 diabetes mellit depression, seizures, -A medication order for reduce blood sugar-fa	, and chronic pain. or Novolog insulin (used to ast acting) per sliding scale pedtime (FSBS 180-200=1) e				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE SURVE COMPLETED			
		FCL045102	B. WIN	3		12/31/2014
NAME OF P	ROVIDER OR SUPPLIER		TREET ADDRESS, CI	Y. STATE. ZIP CODE	 	12/01/2011
		1:	5 EAST MONET			
SOUNDVI	EW FAMILY CARE HOME	E UNIT N F	LAT ROCK, NC 2	3731		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	IE PRE TA	EIX (EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page	e 1	C 330			
	400 notify physician)A medication order for blood sugar-long actition order for the sugar-long action order for the sugar-long action or the	or Levemir (used to reduc ng) 4 units daily at bedtim or Novolin N (used to ntermediate acting) 5 units	e e.			
	Primary Care Physici revealed: -Discontinue current -Change Humulin N (to Levemir 12 units d	bioequivalent to Novolin Naily times one week, then				
	units daily times one week, then 16 units daily. Review of an order written by Resident #1's Endocrinologist dated 12/11/14 revealed: -Levemir 9 units twice dailyHumalog (bioequivalent to Novolog) 4 units before meals three times dailySee attached for sliding scaleKeep glucometer at bedside.					
		nt #1's record revealed the on of a sliding scale for this	-			
	9:45am revealed: -She was the primary in the home 24 hours except she had sched 9am to 7pmThe facility had beer insulin per sliding sca 11/20/14 for Resident-She had taken Residented.		s ed 4.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE SURVEY COMPLETED					
		FCL045102		B. WING			2/31/2014
NAME OF PROVIDER OF	SUPPLIER			RESS, CITY, STA	TE ZIP CODE	,	
NAME OF TROVIDER OF	COOLLEIC			MONET COURT			
SOUNDVIEW FAMILY	CARE HOMI	E UNIT N		K, NC 28731	•		
	ACH DEFICIENC	ATEMENT OF DEFICIEN Y MUST BE PRECEDED LSC IDENTIFYING INFO	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
taken the Transportaken Re-To her k scale ord on 12/11 -To her k Humalog Novolog -She had been giv medicatir referring attached 12/11/14 -She star office an they had Interview 9:53am i -Resider blood su -"[Reside and they and had -"[Local I handling Review 6 #1 dated Endocrin -Blood g and bedfi -Humalo low BG, meal; BG just befo 71-150-1	rter had beer esident #1 to chowledge the der initiated by 1/14. Inowledge the insulin, but insulin. It assumed sien Resident on administrate to that order for sliding so that order for sliding so that on file for the with the Admercealed: In the first that order for sliding so that the first for the file for the first for the file file file file file for the file file file file file file file fil	the appointment, In on vacation, so so the appointment is ere wasn't another by the Endocrinologe resident had new had always been directed the Endocrino #1's folder with he ation record he had with the cale" on the ordered of call the Endocrinologies and a copy of the visit on 12/11/14 ministrator on 12/3 weekend twice done to the Endocrinologies.	she had herself. r sliding gist visit ver taken on blogist had er current d been ten "see ed dated hology he order 4. 30/14 at ue to low inologist and she fell s been vith her." or Resident ent #1's n revealed: every meal 0-Treat ly after injection units; BG .	C 330			

Division of Health Service Regulation

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		ECI 045402	B. WING		4.	0/24/2044
		FCL045102			14	2/31/2014
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STAT	E, ZIP CODE		
SOUNDVI	EW FAMILY CARE HOME	E UNIT N	T MONET COURT DCK, NC 28731			
0/4) ID	QUIMMADV QT	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF (COPPECTION	(V5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 330	Continued From page	e 3	C 330			
C 330	Lunch, Supper) BG 1 2 units; BG 251-300, units; BG 351-400, 7 -Take additional Hum 151-200, none; BG 2 2 units; 301-350, 3 ur Interview with the Su 11:11am revealed: -"Here's the [order] fro office." -"They did not give m -"I assumed she was sliding scale insulin o Endocrinologist] had current orders and eN -The medication orde eMAR system by the -The eMAR system ju time for BG to be obta what dose of insulin t -She was responsible received from a phys -A copy of the order w office where the staff orders entered by the Interview with the Su 2:08pm revealed "[Th scale order dated 12/ faxed over to the office got it." Review of Resident # Electronic Medication	51-200, 1 unit; BG 201-250, 3 units; BG 301-350, 5 units. alog Insulin (bedtime) BG 01-250, 1 unit; BG 251-300, nits; BG 351-400, 5 units. pervisor on 12/30/14 at om the Endocrinologist's e that when I was there." meant to continue the old rder because [the her folder [with the her MAR] in front of him." ars were entered into the pharmacy. Ust popped up prompting ained and then it calculated to administer to the resident. Are for faxing over new orders ician. Was also sent to the main would double check all the expharmacy. Dervisor on 12/31/14 at the Endocrinologist's sliding (11/14] would have been see and the pharmacy if I had	C 330			
	, ,	30/14, 7pm to 9pm was 42 to				
	Review of Resident #	1's December 2014 eMAR				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL045102	B. WING		12/31/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
SOLINDVI	EW FAMILY CARE HOMI	E LINIT N 15 EAST	MONET COURT	-	
30011011	LW TAMILI CARL HOM	FLAT ROO	CK, NC 28731		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
C 330	Continued From page	e 4	C 330		
	sliding scaleThe actual sliding so the eMARThe BG range from 12/10/14, 7pm to 9pm -The BG range from 12/14/14, 7am to 9am sent to the hospital w-Administration times 9am, 11am to 1pm, 4 9pmFrom 12/11/14, 11ar 7am to 9am dose, the of 2 opportunites who was documented as a -On 12/12/14, at 7a to Novolog documented requiredOn 12/13/14, at 7p to	12/11/14, 11am to 1pm until n when Resident #1 was			
	Observation of Resident #1's medications on hand in the facility on 12/30/14 at 3:31pm revealed:				
	Novolog insulinThe label had Resid	ally used multidose vial of ent #1's name with the uctions "use as directed			
	Interview with the Su 1:16pm revealed: -She had taken Resid Endocrinologist for th -She had taken a fold	pervisor on 12/30/14 at dent #1 to the a appointment on 12/11/14. der with the resident's current			

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contained the resident's fingerstick blood sugar

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STATEMENT	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE	SURVEY
			A. BOILDING			
		FCL045102	B. WING		12	/31/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
COLINDVI	EW EAMILY CARE HOME	15 EAST	MONET COURT	7		
SOUNDVI	EW FAMILY CARE HOMI	FLAT RO	CK, NC 28731			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
C 330	Continued From page	e 5	C 330			
	facility she realized we medication order to the physician] had the wrunger -"Since it was just write [Primary Care Physician that day." -"I did not realize the had changed until I compart the what scale the order -She stated she had referring to the same 11/20/14 FL2.	ting the wrong insulin down ian's name] fixed it for me sliding scale for the insulin alled them today to clarify referred too." thought the physician was scale ordered on the				
	Telephone interview with the facility pharmacy on 12/30/14 at 2:00pm revealed: -Resident #1's sliding scale order was from the FL2 dated 11/20/14The order was as follows: Novolog insulin per sliding scale before meals and at bedtime (FSBS 180-200=1 unit, 201-250=2 units, 251-300 = 4 units, 301-350= 6 units, 351-400 = 8 units, greater than 400 notify physician)An order had never been received from Resident #1's Endocrinologist dated 12/11/14.					
	12/30/14 at 3:17pm rd-Resident #1 had bee 12/11/14The order for the slich her visit" and given to -The copy of the order facility on 12/30/14 which by Resident #1's Endintended the resident -Their office had follo	tified medical assistant on evealed: en seen in their office last on the resident and caregiver. er that was faxed to the as what had been ordered ocrinologist and what he had				

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STATEMENT OF DEFICE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION		E SURVEY PLETED
_		FCL045102	B. WING		12	2/31/2014
NAME OF PROVIDER C	R SUPPLIER	STREET A	ADDRESS, CITY, STA	TE, ZIP CODE		
SOUNDVIEW FAMIL	LY CARE HOMI	E UNIT N	T MONET COURT DCK, NC 28731	Г		
1 1 ()	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE
"erratic. Review policy s -Obtain clear ar the med the purp medica directio -Orders immedi -The medicar error change -Place a "Direction medicar Review Resider -On 12/1 -"[The resider on 12/1 -Recom "Encouration weak of med change instabilis Review Resider -On 12/1 -Recom "Encouration medicar recom "Encouration medic	of the facility section on med a written order of concise infedication, the epose of the metion is to be class. The facility sedication admits a label from the ons changed, tion over the interest and the facility of an Accider of the facility of the faci	medication administration dication changes revealed: er from the physician with formation as to the name of exact dosage, the strength, edication, the date the nanged, full administrative ed to the pharmacy inistration record is to be e pharmacy, which reads refer to chart" on the nitial directions. at/Incident Report for et al. "Found resident in floor." do that she fell out of bed. ergency room] at 7am, but stated her leg was feeling at to local emergency room for evaluation. It is to prevent recurrence: It to use call bell when feeling that may have contributed to ext/Incident Report for ext/Inc	C 330	DEFICIE	ENCY)	

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION		SURVEY
			A. BUILDING: _			
		FCL045102	B. WING		12	/31/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
			MONET COURT			
SOUNDVI	EW FAMILY CARE HOME	E UNIT N	CK, NC 28731			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN	OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	COMPLETE DATE
C 330	Continued From page	e 7	C 330			
	-Recommended step: "[Home Health] to eva	s to prevent recurrence: aluate and treat. [Family orimary care to manage				
	dated 12/16/14 reveal admitted to a local ho	spital for treatment on trochanteric fracture of the petes mellitus with				
	and 12/31/14 at 7:55a					
		facility for about 2 months				
	and she really "liked"	ere not well controlled with				
	her medications.	re not well controlled with				
		been an inpatient in a local				
		014 when she fell originally				
		nur and the hospital "did				
	surgery and put a me	-				
		from that hospital to a				
	skilled nursing facility	for rehabilitation.				
		was discharged from the				
		and to the current assisted				
	living facility.					
		ceiving physical therapy with				
		cility two times a week.				
	-"I can walk, but with	a limp. a cane and that helps."				
		during December in the				
	current facility.	daming December in the				
	1	urred on 12/13/14 and she				
		nt to go to the [emergency				
		r my head started hurting. I				
	had a big egg on my					
	-At that point the resid					
		ed and staff sent her out for				

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AND PLAN OF CORRECTION IDENTIF	DER/SUPPLIER/CLIA FICATION NUMBER:		CONSTRUCTION	(X3) DATE SURV	
	TOATION NOMBER.	A. BUILDING: _		JOHN LETE	J
FCL	045102	B. WING		12/31/2	2014
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SOUNDVIEW FAMILY CARE HOME UNIT N	15 EAST M	ONET COURT	г		
COOKE VIEW PAINE OAKE HOME ONLY N	FLAT ROCK	K, NC 28731			
(X4) ID SUMMARY STATEMENT OF I PREFIX (EACH DEFICIENCY MUST BE PF TAG REGULATORY OR LSC IDENTIFY	RECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
c 330 Continued From page 8 evaluation at a local emergency -The resident was evaluated and facility later in the day on 12/13/ -The resident stated she fell aga of 12/14/14 and was sent to the for evaluation where a CT scan images of the bones) of the her she had "reinjured the femur" an "hairline fracture in the bone I st -"The surgeon said it should not since it was a hairline fracture." -The surgeon told her the fractur no time." -The resident believed her blood low did contribute to her fallShe stated she had been "really recent changes the Endocrinolog her insulins and "I'd rather my st real low." Interview with the Administrator 3:57pm revealed: -She stated the Endocrinologist problems Resident #1 had with I could have led to her fallShe stated "He didn't reconcile review the current medication ac record (MAR) her staff had provi during the visitThe Endocrinologist had ordere medications" the resident "wasn -"Since he didn't attach a new so that he was referencing the slidii in the folder with her current MA -"When [the Endocrinologist] ma changes within days she fell." -"The primary care provider star after the hospital discharge and since."	d returned to the 14. in on the morning emergency room (cross sectional left hip revealed and there was a lill had left." be a problem re would "heal in I sugar getting too y upset" about the gist had made to ugar be high than on 12/30/14 at was a fault for the her low BG which this orders" or diministration ided for him and to "discontinue of ton." cale we assumed the grade was scale that was R." and those ted following her	C 330			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			71. BOILBING.			
		FCL045102	B. WING		12/31/2014	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SOLINDVI	EW FAMILY CARE HOME	INIT N 15 EAST I	MONET COURT	r		
	EW FAIRE OAKE HOME	FLAT ROC	K, NC 28731			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
C 330	Continued From page	9	C 330			
	these falls." -On 12/11/14, "It was and she was in and o -"[The relief Supervise had faxed the orders -The order for Reside faxed to the pharmacy elements -"Our office [staff] che what the pharmacy elements -Since the Endocrinol their own form, a copy to the outgoing box for Interview with the Adr 8:50am revealed: -The rehabilitation factors - The rehabilitation	[the Supervisor's] day off ut throughout the day." or] thought [the Supervisor] to the pharmacy." ont #1 had not ever gotten y. ock order changes against inters." logist's order had been on y must not have ever gotten or the office staff to review. ministrator on 12/31/14 at cility where Resident #1 had in before coming to the office to the office staff to the office told them about "problems				
	member on 12/31/14 -She believed Reside changes made by the resident's insulin orde -Resident #1 and she leave the Endocrinolor resident had seen for physician "adjusted h fell twice." -The "doses were too sugars too low at nigh -"A normal blood suga her." -She stated often time Resident #1's orders	ent #1's falls were related to ent #1's falls were revening leveming and she whigh making [Resident #1's] far at night is disasterous for the ent falls were related to after hours or on weekends for the practice physicians did not				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE SUR COMPLETE			
		FCL045102	B. WING	· · · · · · · · · · · · · · · · · · ·	12	2/31/2014
NAME OF P	ROVIDER OR SUPPLIER	STF	REET ADDRESS, CITY, S	TATE, ZIP CODE		
SOLINDVI	EW FAMILY CARE HOME	= LINIT N	EAST MONET COU	RT		
	- TAMIET GARETIONIE	FL	AT ROCK, NC 2873			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
C 330	Continued From page	e 10	C 330			
	has had."	e best care [Resident #1] are physician was capable o 's insulin orders.	of			
	assistant for Residen 12/31/14 at 9:52am re -The Endocrinologist could not come to the -However, she stated	was caring for patients and	t			
	2. Review of an Endocrinologist's order for Resident #1 dated 12/11/14 received from Resident #1's Endocrinologist on 12/30/14 at 11:11am revealed Levemir 9 units at breakfast and bedtime daily.					
	policy revealed medic	medication administration cation administration times ice daily medication to be and 8pm.				
	(eMAR) revealed the	e1's November 2014 Administration Record BG range from 11/25/14, 80/14, 7pm to 9pm was 42 t	o			
	revealed: -A computer generate 12/11/14 for Levemir -The BG range from 12/10/14, 7pm to 9pn -The BG range from	12/1/14, 7am to 9am until n was 45 to 473. 12/11/14, 11am to 1pm until n when Resident #1 was				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL045102	B. WING		12/31/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STAT	E ZIP CODE	•
TO WILL OF T	NOVIDEN ON OUT FEEL		T MONET COURT	,	
SOUNDVI	EW FAMILY CARE HOME	UNIT N	OCK, NC 28731		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
C 330	Continued From page -The Levemir 9 units eMAR to be administe 4:30pm to 5:30pmLevemir 9 units was administered at 6:30a 5:30pm on 12/12/14 a #1 was admitted to th 12/14/14. Interview with the Adr 9:53am revealed: -Resident #1 "fell one blood sugar." -"[Resident #1] had g and they changed he and had a hip fracture -"[Local home health handling aggressive p Interview with the Sup 11:11am revealed: -The Levemir insulin of faxed to the facility ph -The medication orde eMAR system by the -The eMAR system ju time and calculated d to the residentShe was responsible received from a physi -A copy of the order w office where the staff orders entered by the Telephone interview w	was scheduled on the ered at 6:30am to 9am and documented as am to 9am and 4:30pm to and 12/13/14 until Resident the hospital on the morning of ministrator on 12/30/14 at the weekend twice due to low one to the Endocrinologist of medicine all up and she fell et." agency name] has been onlysical therapy with her." opervisor on 12/30/14 at the order dated 12/11/14 was narmacy on 12/11/14. It is were entered into the pharmacy. The proposed up prompting a ose of insulin to administer the for faxing over new orders to a salso sent to the main would double check all the expharmacy.	C 330		
	the order from the fact daily on 12/11/14.	evealed they had received cility for Levemir 9 units twice			
	Telephone interview v	vitn Kesident #1's			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED		
		FCL045102	B. WING		12/31/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
SOUNDVI	EW FAMILY CARE HOME	UNIT N	MONET COURT	ī	
			K, NC 28731		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
C 330	Continued From page	e 12	C 330		
0.330	Endocrinologist's cert 12/30/14 at 3:17pm re- Resident #1 had bee 12/11/14The insulin orders we given to the resident aThe copy of the orde facility on 12/30/14 wa by Resident #1's End- intended the resident -Their office had follow number of years and "erratic." Review of an Accident Resident #1 dated 12 -On 12/13/14 at 7am, -"[The resident] stated Refused to go to [eme- by 9am [the resident] worse."	ified medical assistant on evealed: In seen in their office last on ere printed at the visit and and caregiver. In that was faxed to the as what had been ordered ocrinologist and what he had receive. In wed Resident #1 for a her blood sugars were			
	on 12/13/14 at 9:20ar -Recommended steps "Encourage [resident] weak or unstable. Comed changes 12/11 th instability." Review of an Accident Resident #1 dated 12 -On 12/14/14 at 7am, [The resident] could in checked [blood glucoseResident #1 was sen on 12/14/14 at 7:43ar -Recommended steps "[Home Health] to eva-	in for evaluation. Is to prevent recurrence: I to use call bell when feeling intact physician regarding that may have contributed to interest to the feeling intact physician regarding that may have contributed to interest to feeling interest to feeling interest to feeling interest for interest feeling interest feeling interest feeling interest feeling interest feeling into the feeling interest			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		FCL045102	B. WING		12/31/2	014
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E. ZIP CODE		
			T MONET COURT	_,		
SOUNDVI	EW FAMILY CARE HOME	UNIT N	OCK, NC 28731			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	CTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)		OMPLETE DATE
C 330	Continued From page	: 13	C 330			
	12/11/14"					
	dated 12/16/14 revea admitted to a local ho	spital for treatment on trochanteric fracture of the etes mellitus with				
	Interview with Resident #1 on 12/30/14 at 8:25am and 12/31/14 at 7:55am revealed: -She had lived in the facility for about 2 months and she really "liked" living thereHer blood sugars were not well controlled with her medicationsShe stated she had been an inpatient in a local					
	and broke her left fem surgery and put a me -She was discharged skilled nursing facility -She stated then she	from that hospital to a				
	home health in the faction and the faction walk, but with	•				
	-She had fallen twice current facility.	a cane and that helps." during December in the urred on 12/13/14 and she				
	stated she "didn't war room] at first, but late had a big egg on my l -At that point the resid wanted to be evaluate evaluation at a local e	nt to go to the [emergency r my head started hurting. I head." dent notified staff she ed and staff sent her out for emergency room.				
	facility later in the day	aluated and returned to the on 12/13/14.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:		
	FCL045102	B. WING		12	2/31/2014
NAME OF PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	: ZIP CODE	, ·	
		ST MONET COURT	,		
SOUNDVIEW FAMILY CARE HOME	E UNIT N	ROCK, NC 28731			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
for evaluation where a images of the bones) she had "reinjured the "hairline fracture in the "The surgeon said it since it was a hairline -The surgeon told her no time." -The resident believed low did contribute to hear stated she had be recent changes the Ender insulins and "I'd rareal low." Interview with the Adra 3:57pm revealed: -She stated the Endo problems Resident #* could have led to her eview the current me record (MAR) her stated uring the visit. -The Endocrinologist medications" the residence within days so "The primary care profite affects of the se falls." -On 12/11/14, "It was and she was in and or "[The relief Supervise had faxed the orders"	sent to the emergency room a CT scan (cross sectional of the her left hip revealed e femur" and there was a e bone I still had left." should not be a problem fracture." the fracture would "heal in d her blood sugar getting too ner fall. been "really upset" about the indocrinologist had made to ather my sugar be high than ministrator on 12/30/14 at crinologist was a fault for the indocrinologist was a fault for the indocrinologist was a fault for the indication administration find provided for him had ordered to "discontinue dent "wasn't on." ologist] made those she fell." ovider started following her harge and she's had no falls on changes contributed to [the Supervisor's] day off ut throughout the day." or] thought [the Supervisor] to the pharmacy." ent #1 had not ever gotten	C 330			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED		
		FCL045102		B. WING		1:	2/31/2014
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	·	
			15 EAST N	ONET COURT	Г		
SOUNDVI	EW FAMILY CARE HOME	E UNIT N	FLAT ROCI	K, NC 28731			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORM/	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 330	Continued From page	e 15		C 330			
	-"Our office [staff] che what the pharmacy e -Since the Endocrino their own form, a cop to the outgoing box form." Telephone interivew was member on 12/31/14 -She believed Reside changes made by the resident's insulin orderesident #1 and she leave the Endocrinoloresident had seen for physician "adjusted hell twice." -The "doses were too sugars too low at night." -She stated often time Resident #1's orders by the Endocrinology "get into her chart" in -"[Facility name] is the has had." -She felt a primary cathandling Resident #1 Interview with the Adi 8:50am revealed:	nters." logist's order had bee by must not have ever or the office staff to re with Resident #1's far at 8:30am revealed: Endocrinologist to the es chad recently decided by practice whom the 10 years because the er evening levemir ar high making [Resident." ar at night is disastere es changes made to after hours or on wee practice physicians of the their office. The physician was cap 's insulin orders.	en on gotten eview. mily sted to ne d to e le nd she ent #1's] ous for ekends did not et #1]				
	-The rehabilitation factories been discharged from current facility had nowith blood sugars." -She believed both famedication changes.	n before coming to the of told them about "pro	е				
	Telephone interview vassistant for Residen						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		FCL045102	B. WING		12/	31/2014
NAME OF P	ROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY, STA	TE, ZIP CODE		
SOUNDVI	EW FAMILY CARE HOME	E UNIT N	ST MONET COURT	Г		
	QUILLEN OT		ROCK, NC 28731	PROMPERIO PLANTOS	- 0000000000000000000000000000000000000	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 330	Continued From page	e 16	C 330			
	12/31/14 at 9:52am re -The Endocrinologist could not come to the -However, she stated	evealed: was caring for patients and				
	B. Review of Resident #3's current FL2 dated 8/28/14 revealed diagnoses included: -encephalopathy -urinary tract infections -coronary atherosclerosis -diabetes mellitus -schizoaffective disorder					
		n's order for Resident #3 ed an order to check vital				
	Review of a physiciar dated 9/22/14 reveale regulate blood pressu	. ,				
	Review of a physician's order for Resident #3 dated 11/13/14 revealed: -Lisinopril 10mg daily discontinuedLisinopril 20mg daily.					
	dated 11/20/14 revea	ded after [blood pressure]				
	revealed: -A computer generate dailyLisinopril 10mg was	ed entry for Lisinopril 10mg documented as to 11/13/14 daily at 8am.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		FCL045102	B. WING		12/31/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STA	TE, ZIP CODE	•
COLINDVI	ENVERNILY CARE LIONIE	15 EAST	MONET COURT	r	
SOUNDVI	EW FAMILY CARE HOME	FLAT RO	CK, NC 28731		<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
C 330	Continued From page	e 17	C 330		
	daily beginning 11/14 -Lisinopril 20mg was administered 11/14/14 -A computer generate daily beginning 11/21 -Lisinopril 30mg was administered 11/21/14 Normal blood pressur according to the Natio	documented as 4 to 11/20/14 daily at 8am. ed entry for Lisinopril 30mg /14. documented as 4 to 11/30/14 daily at 8am. re is considered 120/80 onal Institute of Health. Resident #3's November d: essure documented pressure documented			
	revealed:	3's December 2014 eMAR ed entry for Lisinopril 30mg			
	daily. -Lisinopril 30mg was administered 12/1/14	documented as to 12/30/14 daily at 8am.			
	2014 eMAR revealed -On 12/2/14, blood pr 131/109.	ressure documented ressure documented 156/89. pressure documented			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		:D:	1 ` '			OMPLETED	
		FCL045102	В	. WING		12/	31/2014
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRES	SS, CITY, STAT	E, ZIP CODE		
SOUNDVI	EW FAMILY CARE HOMI	E UNIT N	15 EAST MON				
	OLIMA BY OT		FLAT ROCK, N		DDOMDEDIO DI ANI OF CODDE	OTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUL LSC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
C 330	Continued From page	e 18	(C 330			
C 330	Observation of Residhand on 12/30/14 at -There was one bubbt tablets on hand for the line the lower drawer of was a bubble pack of Resident #3There were no table on the medication can linterview with the Sur 10:30am revealed: -"I have been giving [20mg." -"I didn't see the increwas before I started with the fact 4:28pm revealed: -The pharmacy received for Lisinopril 30mg 11/21/14 and signed Administrator. Review of a pharmace 11/21/14 at 5:06pm re-The Administrator significance with the Add 4:45pm revealed:	ent #3's medications on 11:00am revealed: ble pack of Lisinopril 20m e resident. On the medication cart, the Lisinopril 10mg tablets of Lisinopril 30mg street for Resident #3. Dervisor on 12/30/14 at Resident #3] Lisinopril ease to 30mg" because it working in this facility. Filipper and electronic copy of mg daily on 11/20/14. Was filled on 11/20/14. Tablets were delivered of as received by the face of the delivery manifest dated evealed: gined as having received.	ng nere for ringth t 14 at f the n cility d the	330			
	30mg tablets wentThe Lisinopril 30mg medication cart.	now where the Lisinopril tablets were not on the with Resident #3's prima					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		FCL045102	B. WING		1:	2/31/2014
	ROVIDER OR SUPPLIER	EUNIT N	ET ADDRESS, CITY, STA AST MONET COURT FROCK, NC 28731			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
C 330	revealed: -He was not concerned getting the Lisinopril 30 mg daily pressure too lowLow blood pressure resident's risk of falls. Based on observation attempted interview w 12/30/14, Resident #3 interviewable. A plan of protection w 12/30/14 and included and included and included and included and included and included and orders are reconcionall and check for any new Administrative check times weekly to ensure CORRECTION DATE	etant on 12/30/14 at 4:18pm ed about Resident #3 not 30mg daily as ordered. would have made the blood would have increased the as, record review, and vith Resident #3 on 3 was determined not to be eas provided by the facility on d the following: vill review all report of spital discharges to ensure led. idents to all medical/hospital vare of each physician visit w/changed orders. in will be done two to three re compliance.				
C 912	G.S. 131D-21 Declar Every resident shall h 2. To receive care ar adequate, appropriate	laration of Residents' Rights ration of Resident's Rights ave the following rights: d services which are e, and in compliance with state laws and rules and	C 912			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	CONSTRUCTION		E SURVEY PLETED	
		FCL045102	B. WING		12	2/31/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
SOUNDVI	EW FAMILY CARE HOMI	E UNIT N	F MONET COURT OCK, NC 28731	Г		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
C 912	Continued From page	e 20	C 912			
	review, the facility fail received care and se appropriate and income and state laws and ruto medication administrate findings are: Based on observation review the facility failed Levemir insulins and as prescribed for 2 of (Resident #1 and Resident #2 and second sec	ns, interviews and record led to ensure residents rvices which are adequate, appliance with relevant federal ules and regulations related stration. n, interview, and record ed to assure Humalog and Lisinopril were administered f 3 sampled residents sident #3). [Refer to tag G .1004(a) Medication				

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